**COMMONWEALTH OF KENTUCKY**
**PERSONNEL CABINET**
**DEPARTMENT FOR EMPLOYEE INSURANCE**

# 2007 HEALTH INSURANCE UPDATE FORM

***Do NOT use this form to add or drop dependents. Insurance Coordinator complete form.***

## GENERAL INFORMATION (*REQUIRED*)

| SOCIAL SECURITY NUMBER | COMPANY NUMBER |
|---|---|
| NAME | COMPANY NAME |

☐ **TERMINATION:** DATE EMPLOYMENT ENDS_____ DATE INSURANCE TERMINATES_____

*Reason:* ☐ Resigned ☐ Retired ☐ LWOP ☐ Death ☐ Military ☐ Other_____

☐ **REINSTATE:** DATE RETURNED TO WORK _____ DATE INSURANCE EFFECTIVE _____

*Reason:* ☐ Rehired ☐ FMLA ☐ LWOP ☐ Military ☐ Other_____

☐ **TRANSFER**

- ***To be completed by the <u>NEW</u> company***
- ***No changes to current coverage are allowed on this form***

| | |
|---|---|
| PRIOR<br>COMPANY #_____ | NEW<br>COMPANY #_____ |
| LAST DATE WORKED AT<br>PRIOR COMPANY_____ __ | DATE HIRED AT NEW<br>COMPANY_____ |
| COVERAGE END DATE<br>FROM PRIOR COMPANY #_____ | COVERAGE BEGIN DATE<br>AT NEW COMPANY #_____ |

## OTHER CHANGES OR CORRECTIONS FOR SELF ☐ SPOUSE ☐ CHILD ☐

☐ **NAME** **NEW** _____

**PREVIOUS** _____

☐ **NEW ADDRESS (where mail received)**_____

**CITY:**_____ **STATE:**_____ **ZIP CODE:**_____

**EMAIL:** _____

☐ **SSN** **CORRECT**_____ **INCORRECT** _____

☐ **DATE OF BIRTH** _____ ☐ **OTHER** _____

| EMPLOYEE SIGNATURE | DATE | COORDINATOR SIGNATURE | DATE |
|---|---|---|---|
| | | | |

Insurance Coordinator: Mail this form to 200 Fair Oaks Ln., Suite 501, Frankfort, KY 40601